Patient Centered Medical Home and Data Quality

July 2015

Overview

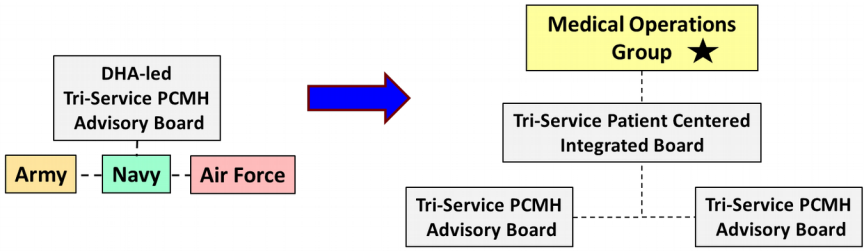
- Patient Centered Medical Home (Primary Care): Implementation to Optimization
- Growing the Primary Care Base
- Expectations and Goals
- Importance of Data Quality
- Performance
- Warfighter Considerations
- HRO Implications and Way Ahead

Why PCMH?

- MHS direct care system enrollees reported what they wanted from primary care:
  - Better continuity with a primary care manager (PCM)
  - Better access to care, especially for acute needs
  - Coordinated, integrated care
  - More convenient parking
- In 2009, the Military Health System (MHS) selected Patient Centered Medical Home (PCMH) model of care to:
  - Maintain maximum patient satisfaction by meeting patient needs
  - Increase evidence-based effectiveness of care
  - Reduce growth of healthcare costs

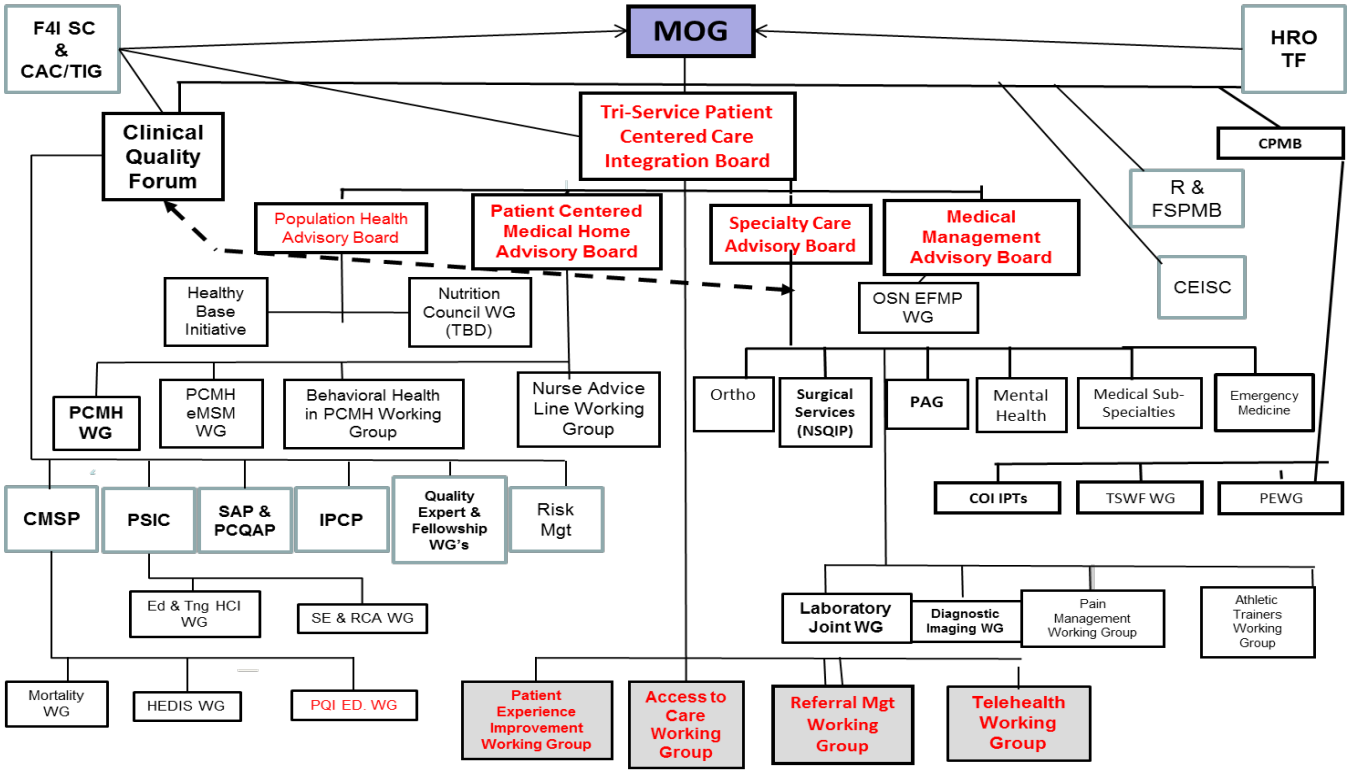
Implementation

- MHS PCMH Policy signed Sep 2009 directed development of Army, Navy and Air Force PCMH operating instructions and implementation in all 440+ primary care clinics
- Common standards needed to drive consistency across all Uniformed Services
  - Tri-Service governance of primary care
  - Funding: “Get Well” staffing model
  - National Center for Quality Assurance (NCQA) PCMH Recognition
  - Common measures and goals



DHA Support of Governance and Service Execution

- Services collaborating on standardization and/or standard processes through governance
  - ❑ "What is the Tri-Service position?"



Transforming and Optimizing Primary Care

- Cultural Change: Team-based Workflow to enhance access
  - Virtual health
  - Nurse-run walk-in clinics for common acute conditions
  - Proactive high utilizer outreach
- Embedding BH, Pharmacy and PT based on population's needs
- Tri-Service team-based workflow (TSWF) in AHLTA with embedded clinical practice guidelines (CPGs)
- Continuous process improvement based on leading practices
- Enrollment-based capitated financing (not FFS-based)
- Evidence-Based and Data-driven
  - Relevant, Timely, Accurate and Actionable: 4th letter MEPRS was critical to driving performance improvement to the most actionable level!
- We rely on the work you do everyday to let us know how we are doing … and what to do next (or not do)

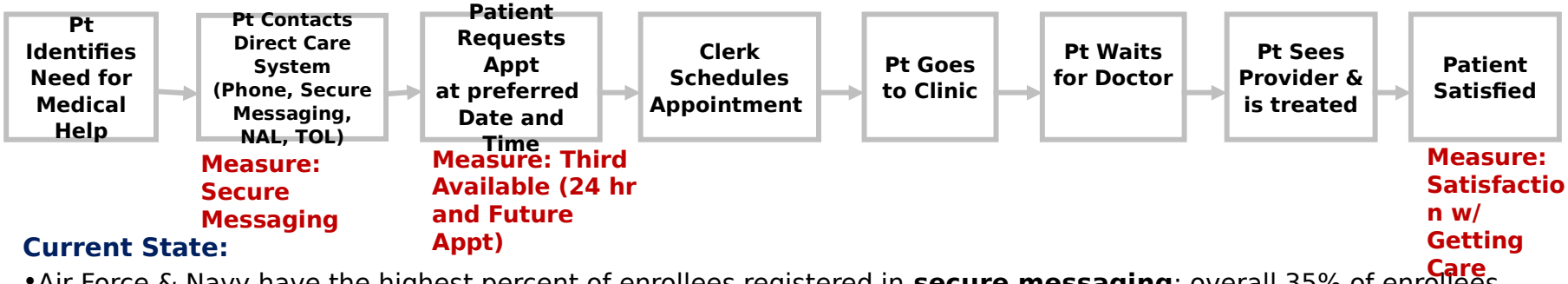
Goals and Performance Measurement

- Key to Success: Common measures and goals based on standard central data collection
  - ***Near-term*** – Improve access and continuity
  - ***Mid-term*** – reducing unnecessary utilization, integrate Behavioral Health into primary care, recapture primary care (reduce leakage), decrease specialty care utilization, improve quality through evidence-based care and increase medical readiness of our warfighters and their families
  - ***Longer-term*** – Improve beneficiary health status and outcomes, increase Medical Treatment Facility (MTF) capacity and then recapture enrollment from private sector to optimize MTF resources and ensure a ready medical force

Priority 1 - Improve Access

Background

•Access to Care is strategically important because it strengthens patient partnerships and decreases the likelihood that patients will seek alternative care venues. In turn, we should see an increase in continuity of care and patient satisfaction, and a reduction in purchased care costs.



Current State:

•Air Force & Navy have the highest percent of enrollees registered in **secure messaging**; overall 35% of enrollees registered; thresholds not yet approved by governance.

•Navy has the best performance on average number of days to **third next 24 hour**; over 50% of appointments are available on a 24-hour basis. Overall performance on average number of days to **third next future** exceeds goal of 7 days or less

•To date, no component has met the FY15 goal of a 2% annual improvement against previous Service performance on **Patient Satisfaction with Getting Care When Needed**

MEASURE	PERFORMANCE					
	MHS	*A*	*N*	*AF*	*NCR-MD*	*PSC*
% of Direct Care Enrollees in Secure Messaging	35%	27%	42%	40%	39%	NA
Average Number of Days to Third Next – 24 Hour	1.5d	1.5	1.0	1.7d	2.1d	NA
Average Number of Days to Third Next – Future	6.6d	6.5d	6.6d	6.5d	11.3d	NA
Satisfaction with Getting Care When Needed	85%	82%	90%	90%	80%	90%

Goals/Targets

•% of Direct Care Enrollees in Secure Messaging (data as of 31 Mar 15): 50% (Exploratory Measure pending Governance approval)

•Average Number of Days to Third Next -24 Hour (data as of 30 Apr 15): 1 day (or less)

•Average Number of Days to Third Next – Future (data as of 30 Apr 15): 7 days (or less)

•Satisfaction with Getting Care When Needed (data as of FY15Qtr1): 2% improvement in each Service (data currently in Carepoint has not been validated by DHA/Decision Support)

Source: MHS R&A

Improving Access

- **Baseline:** PCMHs deliver care to >1.1M enrollees per month; however, some patients still report difficulty in obtaining appointments and variance in MTF protocols
- **Top Reasons for gaps in performance**:
  - Not enough appointments available in templates; and not enough of them available on a 24-hour basis for acute needs
  - Available supply of acute appointments not matched to patient demand by day of week, time of day (one reason >20% of acute appointments are unbooked)
  - Lack of extended/weekend hours
  - Not using team-based workflow to integrate NAL, secure messaging and walk-in clinics for common acute problems (strep throat, uti,)
- **Current strategies to improve access:**
  - ***First Call Resolution***: Implement policy to ensure patients do not have to call back for an appointment (first call resolution); if no ability to meet patient needs with MTF resources, refer to UC in network
  - ***Simplified Appointing***: more appointments on the books; goal of 50% acute (currently at 46%) and appointing based on patient preference
- **Future/potential strategies:**
  - Tri-Service guidance on extended and weekend hours to include MTF UC, if resources permit
  - New measures tied to the number of expected appointments on the books based on enrollee demand
  - Guidance on matching acute appt availability by time of day to demand (e.g. after school and after work)
  - Expand protocols for RN-run walk-in clinics for common acute conditions (sore throat)
  - We are evaluating this process from the patient and MTF perspective during MTF site visits/patient listening tours

Priority 2 (Recapture – Growing the Primary Care Base)
Increase Direct Care Primary Care Capacity

Defense Health Agency

Background

- Maximizing enrollment capacity will support a medically ready force and a ready medical force
- Increasing direct care enrollment will decrease purchase care costs through capture of market share
- Primary care capacity is achieved by increasing enrollment to 1,100 per adjusted FTE ; the goal of 1,100 to 1 can be increased as primary care utilization decreases through effective demand management

Measure: Total Enrollment

Current State

- Navy and NCR MD have increased total enrollment; overall, enrollment has increased 0.1% as of Mar 15
  - Air Force and Army are recapturing patients while the size of their force decreases
- MCSC enrollment has decreased steadily

Current Month	Rolling 12 Months
FY2015 FM6	FY2014 FM7 thru FY2015 FM6

	Target (FY14 Avg)	Current Month	Current Month % Above/Below Target	Distance To Target	Rolling 12 Months	Rolling 12 Months % Above/Below Target
Service						
Air Force	1,130,830	1,101,595	(2.6%)	(29,235)	1,116,356	(1.3%)
Army	1,372,651	1,358,509	(1.0%)	(14,142)	1,368,961	(0.3%)
DHA–NCR	135,896	138,059	1.6%	2,163	137,223	1.0%
Navy	948,272	975,344	2.9%	27,072	968,450	2.1%
MCSC	NA	1,244,537	NA	NA	1,285,460	NA
Total (Minus MCSC)	3,587,649	3,573,507	(0.4%)	(14,142)	3,590,990	0.1%

MEASURE	PERFORMANCE					
	MHS	*A*	*N*	*AF*	*NCR-MD*	*PSC*
Total Enrollment	**3.59M 0.1%**	**-0.3%**	**2.1%**	**-1.3%**	**1.0%**	**N/A**

Goal/Target

- Total Enrollment: 0-5% growth by the end of FY15
- Rate calculated based on “rolling 12” performance compared to the Target (FY14 Average)

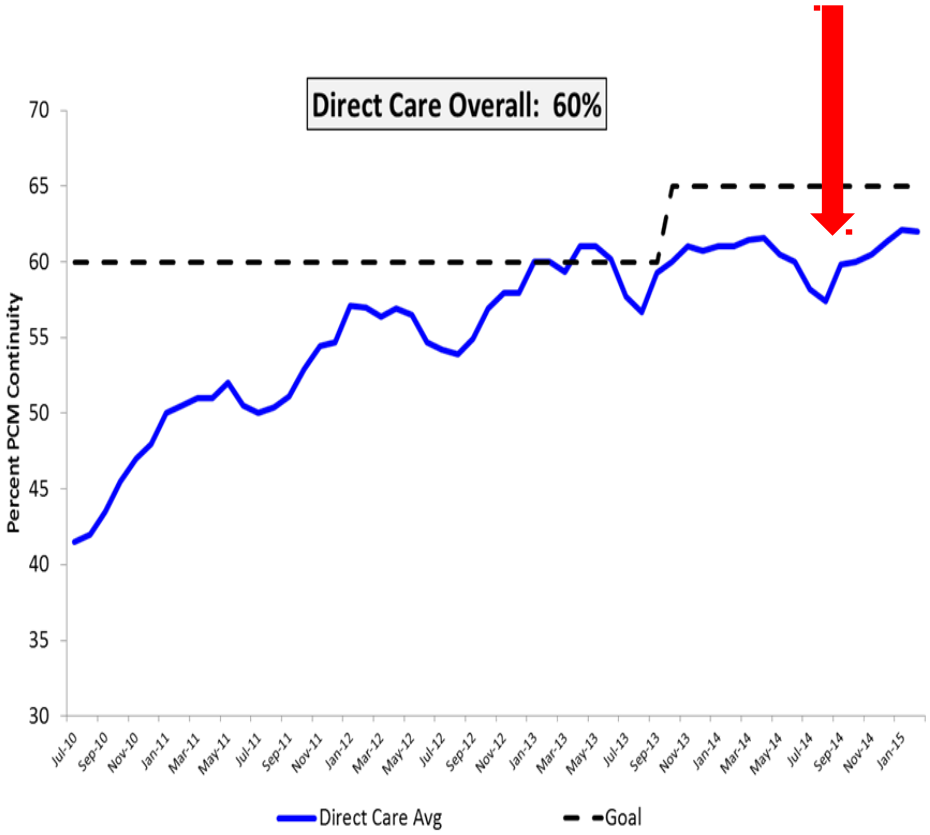
Source: MHS R&A

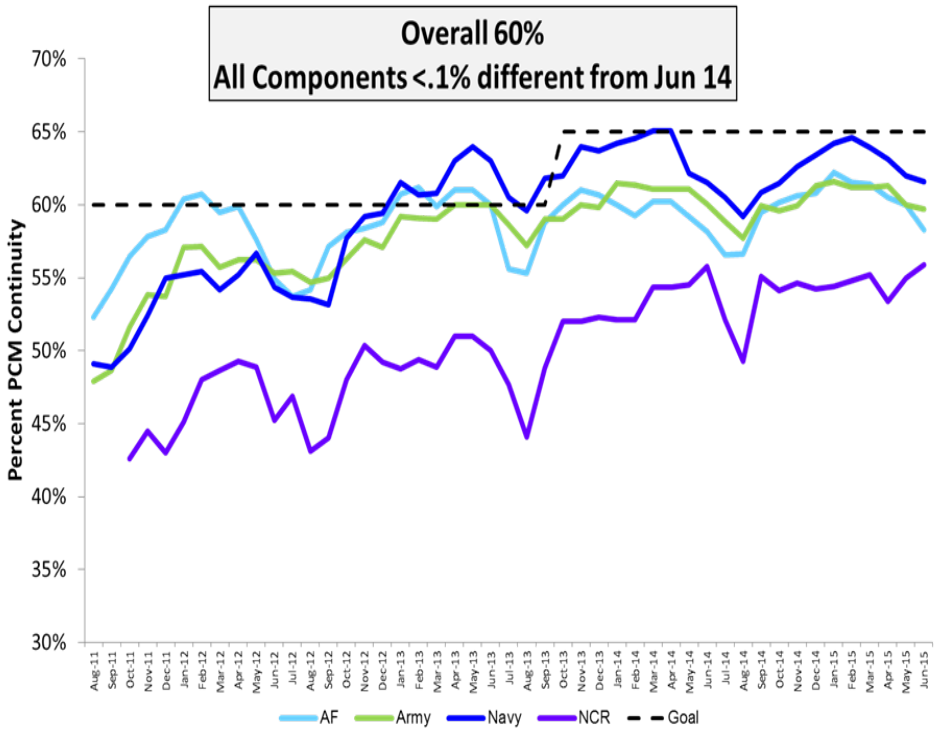
Increasing Primary Care Capacity

- **Baseline:** Current enrollment goal is to **meet** or exceed FY14 goal; a robust enrollment base is critical to maintaining a medically ready force and a ready medical force
- **Top Reasons for gaps in performance**:
  - Army and Air Force have worked to increase enrollment despite post-contingency force contraction (e.g. AF lost 40K beneficiaries; enrolled 13K other beneficiaries, which mitigated loss of eligible beneficiaries)
  - Some MTFs have not actively enrolled beneficiaries because their PCMHs are not sufficiently mature to handle additonal demand; beneficiaries should only be enrolled if care can be provided within access standards
  - Provider and support staff true availability varies
- **Current strategies to increase enrollment and capacity:**
  - Service efforts to increase provider and support staff availability; reduce administrative and other duties
  - Implement enhanced access/demand management to reduce enrollee primary care utilization rates; if utilization rates decrease, then capacity increases.
  - Reducing unnecessary face-to-face utilization by proactive outreach via telephone or secure messaging; use of standard protocols for nurse-run walk-in clinics for common acute conditions; and utilization of embedded behavioral health and other team members to address high utilizers.
  - Enroll from network if capacity exists
- **Future/potential strategies:**
  - Services educate/train staff on enhanced access techniques to reduce demand/increase capacity
  - Services/DHA promote enhanced access opportunities to patients (secure messaging, NAL, etc.)

PCM Continuity May 10 – Jun 15 Averaging 60%; >90% Team Continuity

MHS Review

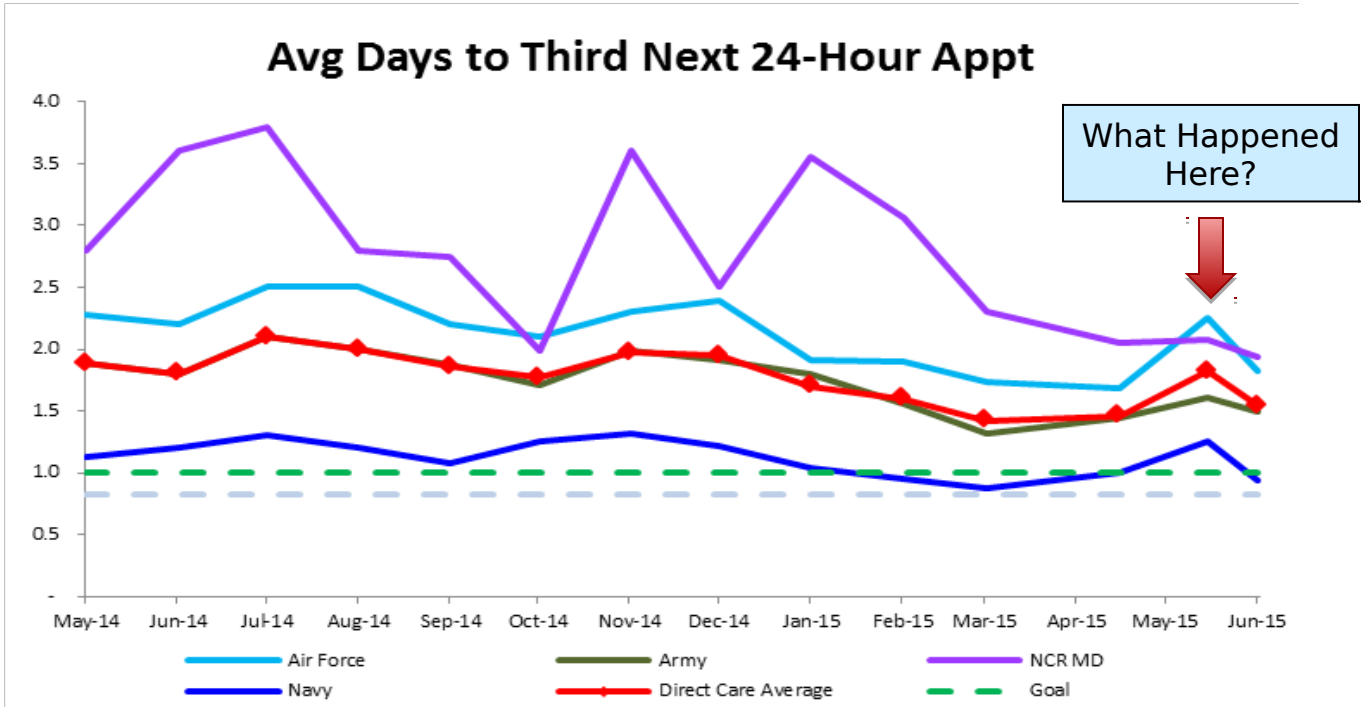




Source: TOC

Average Days to Third Next 24-Hour Appointments

- Overall performance improved 15% in Jun 15 compared to May 15 (One month)

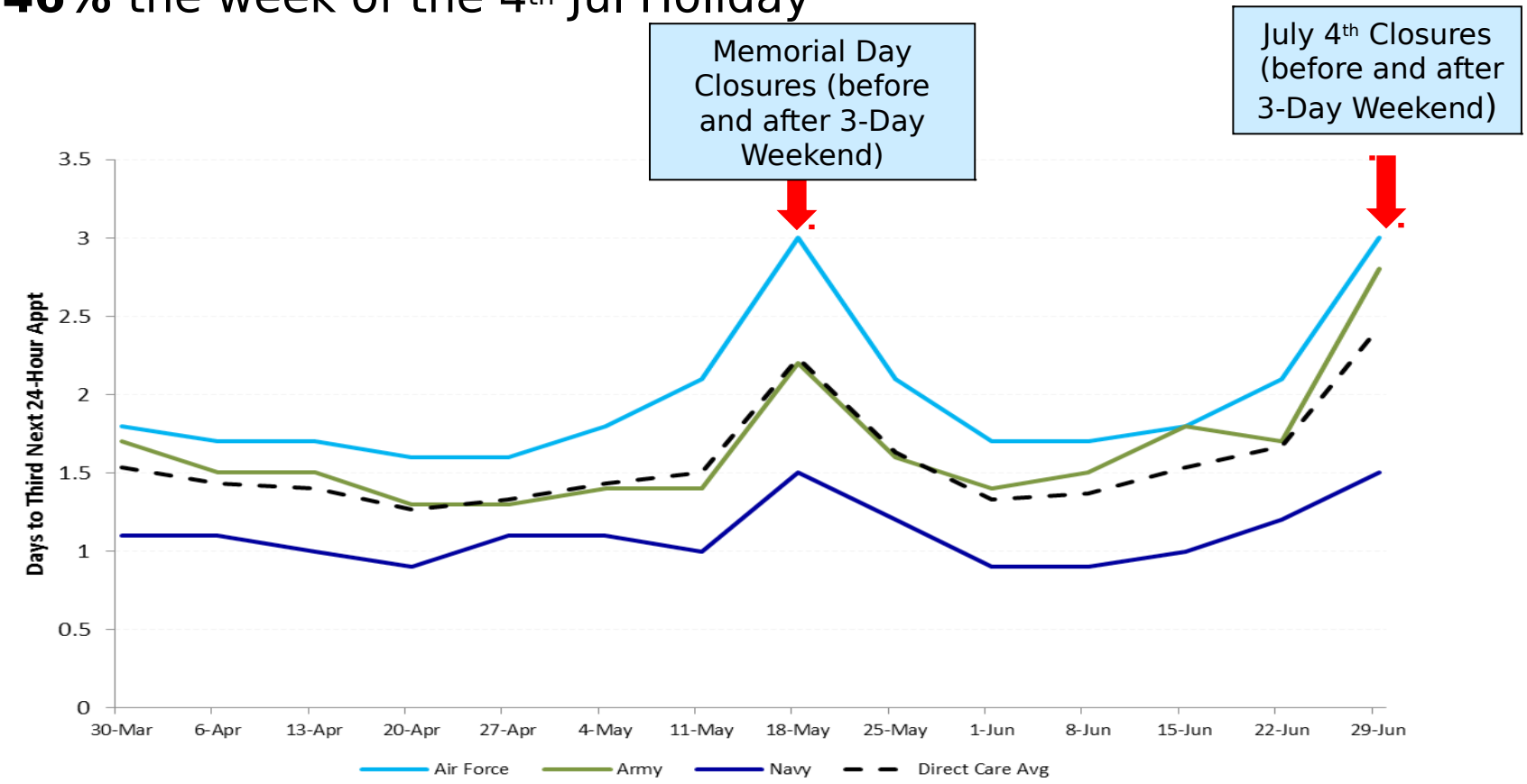


	Air Force	Army	Navy	NCR MD	Overall
Third Next 24-Hour	1.83	1.49	0.94	1.94	1.54

Source: TOC

Holidays + family + training days + picnics/installation events (especially when held consecutively) negatively affect performance/access

- Performance **declined 49%** the week of 18 May compared to previous week and recovered 40% by 1 Jun; **declined again 46%** the week of the 4th Jul Holiday

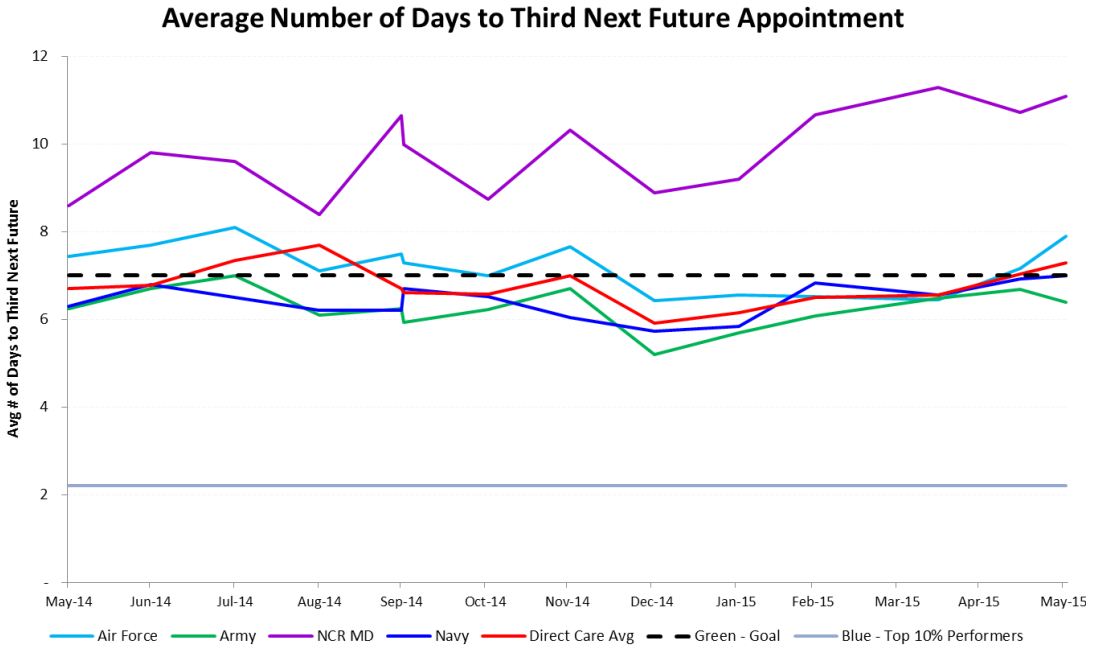


and Navy performance better than reported here as each include NCR MD MTFs

Source: TOC

Average Days to Third Next Future Appointments

- Overall performance declined 4% from 7.0 in May 15 to 7.3 in Jun 15 as MTFs adjust to accommodate patient demand for 24 hour care.



	Air Force	Army	Navy	NCR MD	Overall
Third Next Future	7.9	6.4	7.0	11.1	7.3

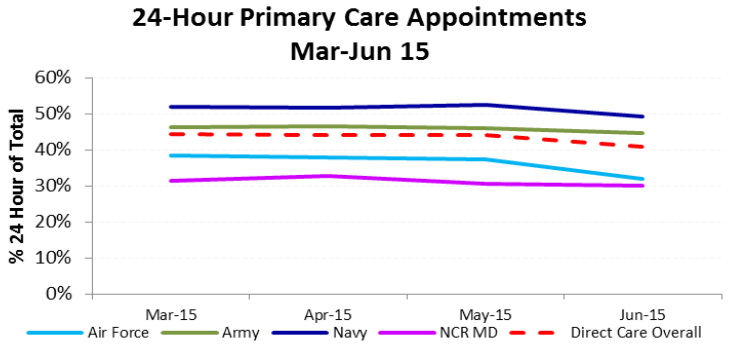
Source: TOC

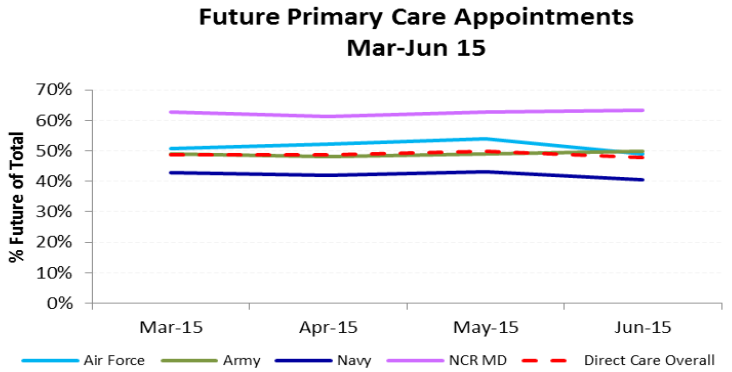
Planned Appointments Mar – Jun 15

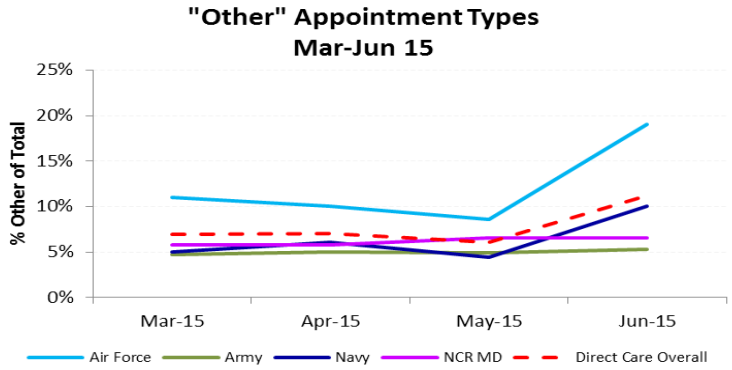
- **"Other" growing at expense of 24-Hour appointments**
  - Not the trend we want
  - "Other" appointment types booked rate is far lower than average

24-Hour	Mar-15	Apr-15	May-15	Jun-15
Air Force	38%	38%	38%	32%
Army	46%	47%	46%	45%
Navy	52%	52%	53%	49%
NCR MD	31%	33%	31%	30%
Direct Care Overall	**44%**	**44%**	**44%**	**41%**
FTR	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**
Air Force	51%	52%	54%	49%
Army	49%	48%	49%	50%
Navy	43%	42%	43%	41%
NCR MD	63%	61%	63%	63%
Direct Care Overall	**49%**	**49%**	**50%**	**48%**
Other	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**
Air Force	11%	10%	9%	19%
Army	5%	5%	5%	5%
Navy	5%	6%	4%	10%
NCR MD	6%	6%	7%	7%
Direct Care Overall	**7%**	**7%**	**6%**	**11%**

Source: TOC

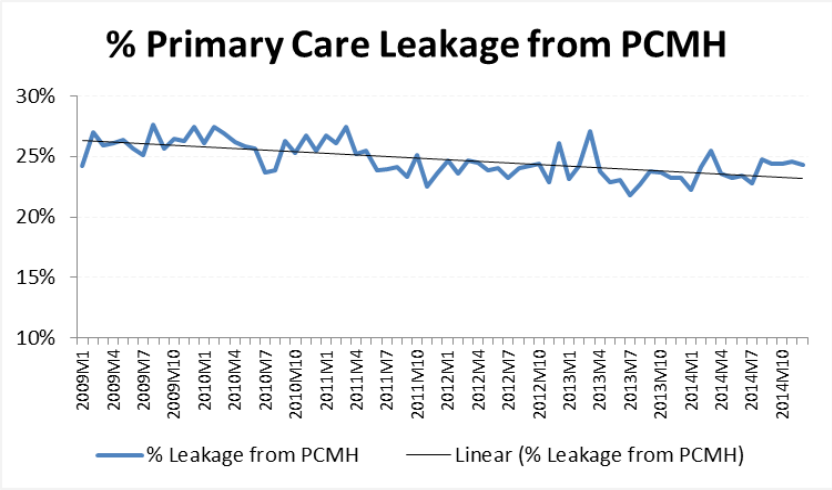


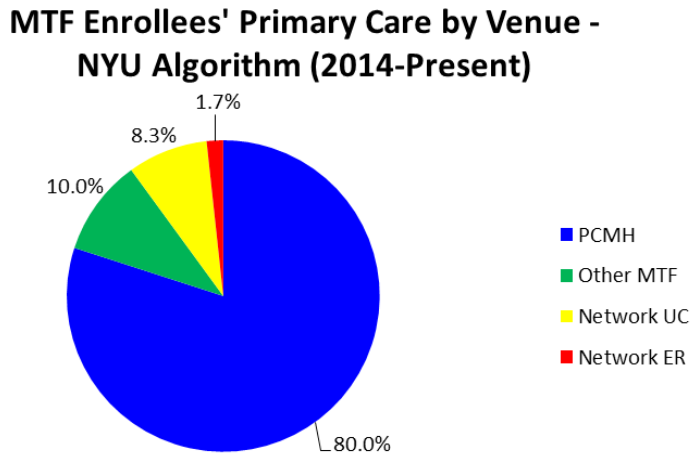




Primary Care “Leakage”

- Leakage defined as primary care workload delivered outside the primary care product line at enrollee's MTF
- “Recapturable” ER Visits/Enr declined 13% over last 18 Months
- Problems with the leakage metric?





Source: M2/Kennell

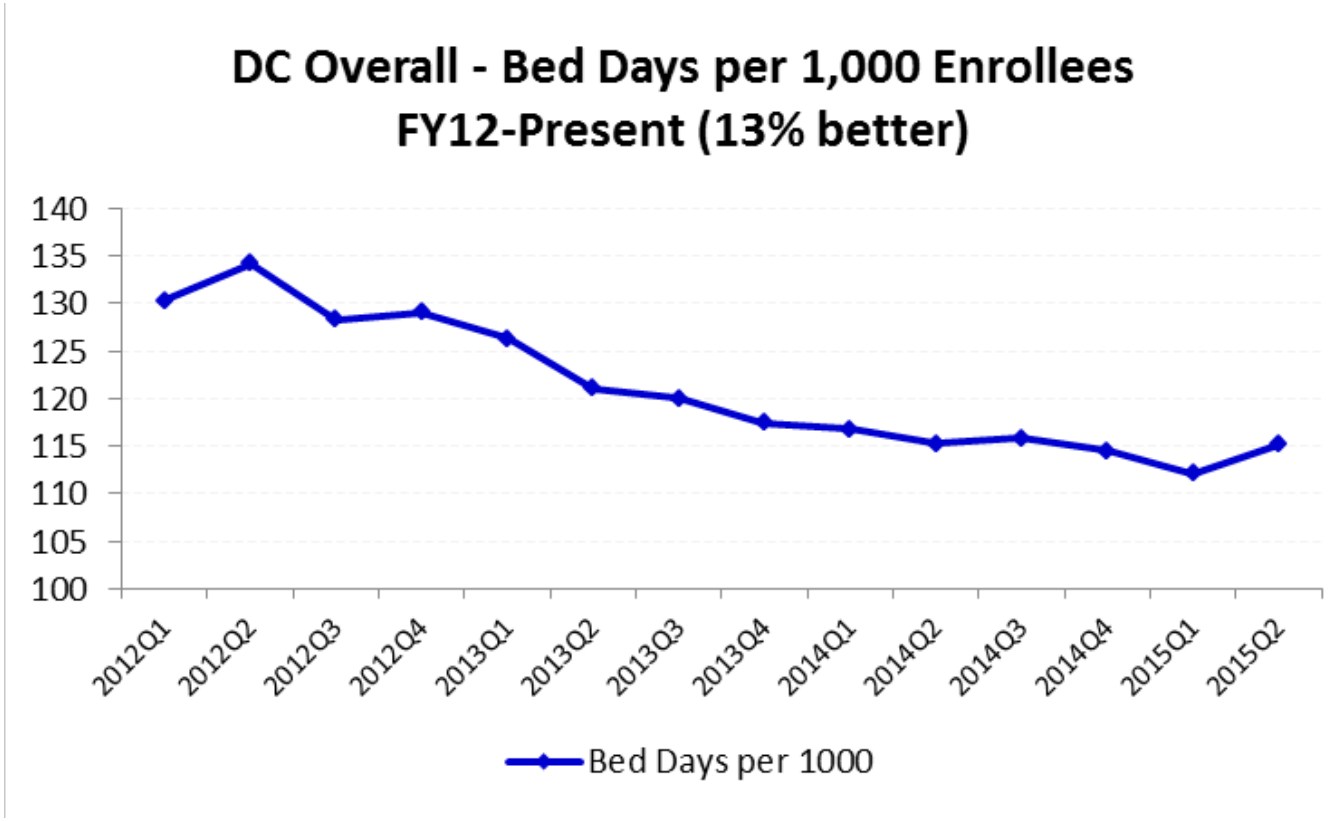
High Utilizer Data and Outreach

- Most Expensive 1%
  - Behavioral Health
  - Musculoskeletal
  - Neoplasms
- CHUP
- Enrollees with 10+ DC or PSC ER visits per year
  - Approximately 5K enrollees
  - Who are they?
- Enrollees with 10 or more primary care visits per year
  - National average is 3.2
  - Kaiser Permanente plans for 2.2-2.9 PCMH visits/year/enr
  - MHS average

Source: M2/Kennell

Inpatient Days for our Enrollees

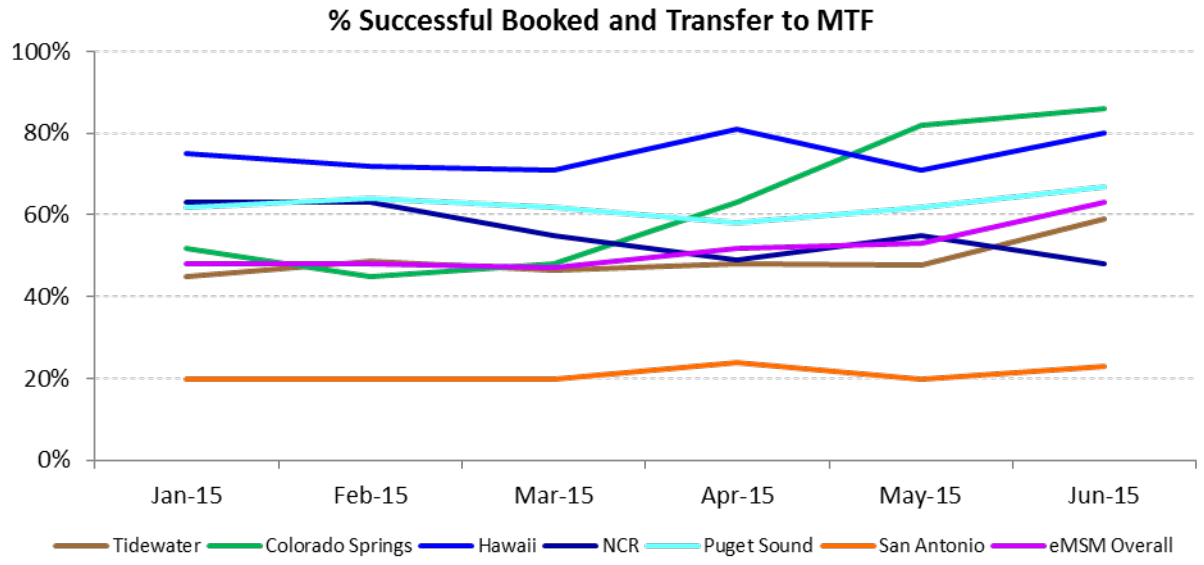
- Bed Days per 1,000 enrollees improved 13%



Source: M2/Kennell

Percent of Eligible Calls Successfully Booked or Transferred to PCMHs

- Successful include both those successful booked in CHCS and those NAL warm transfers accepted by PCMH
  - ❑ 63% overall eMSMs in Jun 15, up from 50% average Jan–May 15
  - ❑ Successful transfers avoided $685K in network UC visits

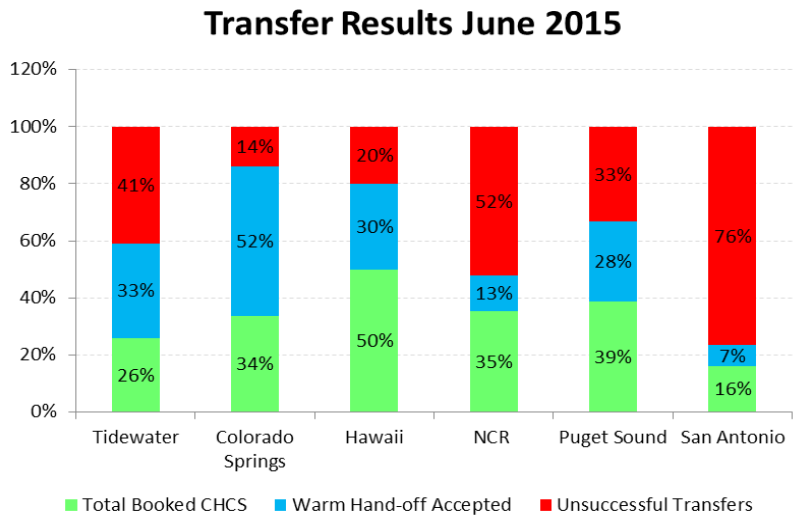


Colorado Springs and Hawaii have highest successful transfer rate

Source: NAL/WRR

Reasons for Unsuccessful Transfer

- Top reason for unsuccessful warm transfer to PCMHs is “phone not answered”
  - ❑ Potential revenue lost due to phone not answered/busy is $380K Jan-Jun 15
- Biggest improvement: Colorado Springs eMSM improved successful booking/transfer rate from avg 52% (Jan-Apr 15) to avg 84% (May-Jun15)

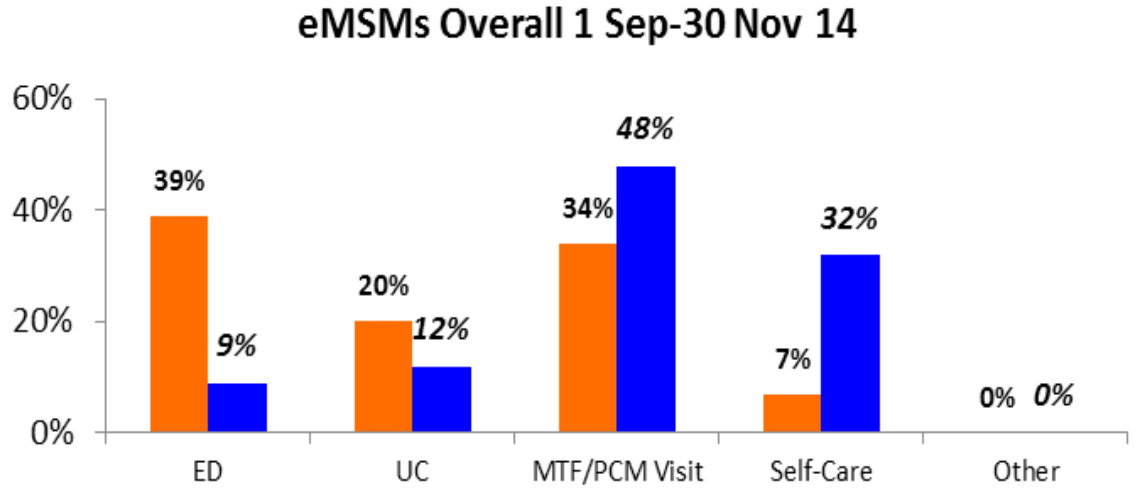


Disposition of Eligible Calls	Jun 15 All eMSMs
Successful - Booked in CHCS	32%
Successful - Warm Transfer Accepted	31%
Unsuccessful - Patient Refused	1%
Unsuccessful - MTF says they are fully booked	11%
Unsuccessful - MTF did not answer phone	18%
Unsuccessful - MTF phone is busy	2%
Unsuccessful - MTF Refused for other reasons	4%
Unsuccessful - Other	1%

Source: NAL/WRR

Costs Avoided/Saved per Call M2 Analysis 1 Sep-30 Nov 1

- NAL successfully advised patients on most clinically appropriate level of care



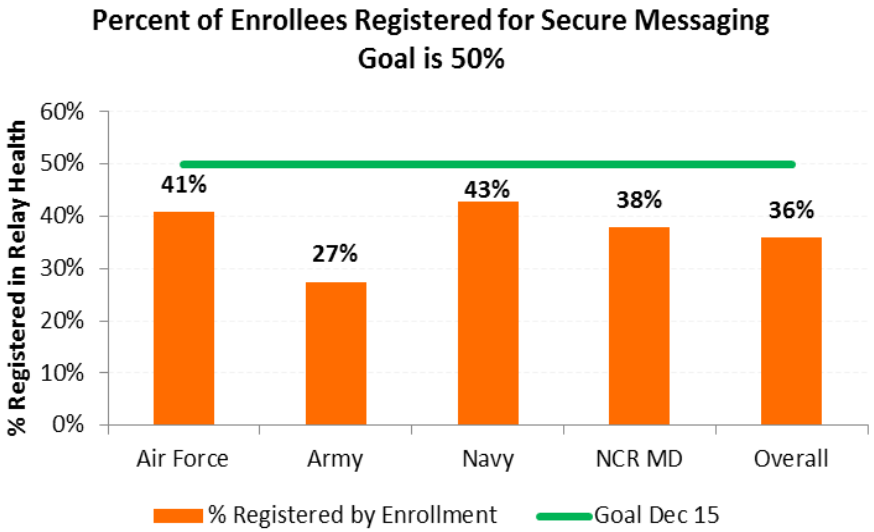
Net Costs Avoided/Saved: $97 per call (Range $154 Hawaii - $77 Tidewater)

	Pre-Intent			RN Advice			M2 Results				
All eMSM	Number	Percent	Est Cost	Number	Percent	Est Cost	Number	Percent	Est Cost	Estimated Cost/Savings per Call	
ED	7,722	39%	$ 3,088,719	2,073	10%	$ 829,200	1,718	9%	$ 687,200	Potential Costs	$4,141,841
UC	4,069	20%	$ 528,964	4,620	23%	$ 600,600	2,350	12%	$ 305,500	M2 Est Costs	$1,724,662
MTF/PCM Visit	6,807	34%	$ 524,158	7,005	35%	$ 539,385	9,506	48%	$ 731,962	Avoided Costs	$2,417,179
Self-Care	1,397	7%	$ -	6,108	31%	$ -	6,421	32%	$ -	Costs Avoided per Call (est)	$ 121
Other	-	0%	$ -	189	1%	$ -	-	0%	$ -	Contract Cost per Call	$ 24
Total	**19,995**		**$ 4,141,841**	**19,995**		**$ 1,969,185**	**19,995**		**$ 1,724,662**	**Net Savings per Call (est)**	**$ 97**

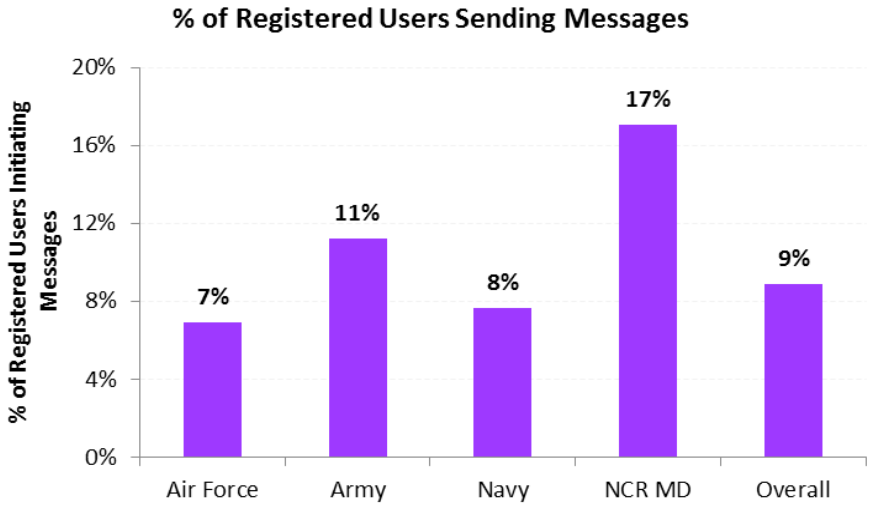
Source: M2/Kennell

Secure Messaging

- Step 1 is getting enrollees registered for secure messaging (36% overall in May 15)
- Step 2 is encouraging use to increase satisfaction, enhance access and reduce face-to-face appointment demand (9% overall in May 15)



As of 31 May 15	Air Force	Army	Navy	NCR MD	Overall
% Registered by Enrollment	41%	27%	43%	38%	36%
Registered Enrollees	453,412	372,870	341,291	54,110	1,221,683

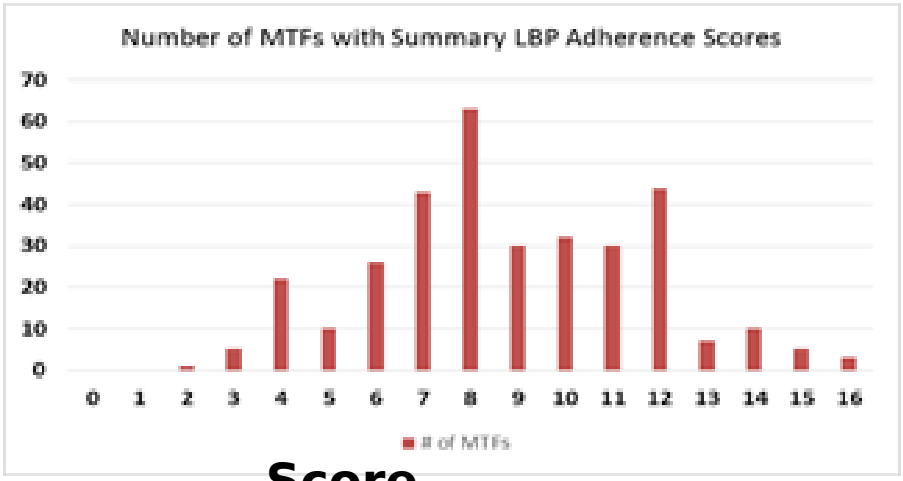


As of 31 May 15	Air Force	Army	Navy	NCR MD	Overall
% of Registered Users Sending Messages	7%	11%	8%	17%	9%

Source: Relay Health/TOC

Quality - TSWF and CPGs

- TSWF Forms and 20+ embedded CPGs to drive team-based workflow, evidence-based care and better outcomes (at lower cost)
- Now used for 83% of PCMH encounters (available by MEPRS)
- CPG use and outcomes can be tracked and evaluated (LBP and Diabetes)



Scores	#of MTFs	%MTFs
12+	69	21%
11-Aug	155	47%
<8	107	32%

Source: TSWF Team

MTF	%without Rx	%with Hx	%with PE	%not imaged	no Rx	Hx	PE	image	no Rx	Hx	PE	image	sum	#of encounters	DMIS Nar	total score
1	97.4%	76.9%	20.5%	69.2%	4	2	0	1	4	2	0	1	7	39	1	7
2	87.5%	50.0%	25.0%	50.0%	3	0	0	0	3	0	0	0	3	8	2	3
3	86.7%	88.9%	2.2%	91.1%	3	3	0	4	3	3	0	4	10	45	3	10
4	90.9%	100.0%	45.5%	100.0%	4	4	2	4	4	4	2	4	14	11	4	14
5	98.4%	71.9%	50.0%	76.6%	4	2	3	2	4	2	3	2	11	64	5	11

Warfighter Needs

- Operational Medical Homes are designed to maintain warfighters' peak performance
  - Marine Centered Medical Homes
  - Submarine Centered Medical Homes
  - Fleet Centered Medical Operations
  - AF Operational Medical Homes
  - Solider Centered Medical Homes

- Each operational medical home type is unique to warfighter requirements and available space (aircraft carrier, etc.)
- Services tied to conditions prevalent in this patient population
  - Embedded Physical Therapy and Behavioral Health resources

Organization (HRO) Implications and Way Ahead

- Principles of a HRO:
  - Transparency
  - Elimination of variance
  - Standardization/standard processes
  - Continuous improvement using facts/accurate data
- Are we using the right measures? What additional measures will drive improvement?
- MEPRS Standardization
- Specialty Care
- Referral Management
- MTF Leading Practices Validation will drive additional Tri-Service Guidance

Team-based care includes you.
Thank you for all you do!